DURANGO REPRODUCTIVE

I give permission to Durango Reproductive Medicine to receive and transmit information relating to my health care.

Please check which of the following methods we may use to contact you. Home phone ___ Cell phone ___ Work phone___ email ___ leaving a message on an answering machine___ US mail___ other, please specify____

I give permission to provide my medical information to my Spouse/Partner ____

By signing this form, I am consenting to Durango Reproductive Medicine to use and disclose personal health information to carry out treatment, payment or health care related matters.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Durango Reproductive Medicine may decline to provide treatment to me.

____ ___________________
Signature of Patient/Legal Guardian Date

____
Patient's Name (Please Print)

____
Legal Guardian Name (Please Print)